PATIENT INFORMATION & HEALTH HISTORY FORM

Date: ____________

Last Name: ____________ **First Name:** ____________ **MI:** ______

Date of Birth: ____________ Sex: M F Social Security Number: ____________

Address: ____________ City: ____________ Zip: ____________

Home Phone: ____________ Cell Phone: ____________

Email Address: ____________

Marital Status: S M W D Spouse Name: ____________ Spouse DOB: ______

Emergency Contact Name: ____________ Relationship: ____________

Best number to contact: ____________

Medical Doctor:	Current Eye Doctor:
Pharmacy Of Choice:	Location/Phone:

Do you wear glasses: Y / N Do you wear contacts: Y / N ***Our clinic does not prescribe hard contact lenses.**

Medications: Please ***SEND A LIST OF YOUR MEDICATIONS*** and dosages or list below (including OTC meds & supplements).

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Surgical History:

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	Family History	Mother	Father	Sibling	Child	Grandparent
☐	Cataracts	☐	☐	☐	☐	☐
☐	Glaucoma	☐	☐	☐	☐	☐
☐	Macular Degeneration	☐	☐	☐	☐	☐
☐	Retinal Detachment	☐	☐	☐	☐	☐
☐	Diabetes	☐	☐	☐	☐	☐
☐	Strabismus / Muscle Problems	☐	☐	☐	☐	☐
☐	Hereditary Eye Disease	☐	☐	☐	☐	☐
☐	High Blood Pressure	☐	☐	☐	☐	☐
☐	Heart Attacks / Disease	☐	☐	☐	☐	☐
☐	Cancer / Type / Location	☐	☐	☐	☐	☐
☐	Kidney Disease	☐	☐	☐	☐	☐
☐	Strokes	☐	☐	☐	☐	☐
☐	Arthritis	☐	☐	☐	☐	☐
☐	Thyroid Disease	☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐	☐

See back of form

REVIEW OF SYSTEMS:

Do you have a history of or are you being treated for:

Ears, Nose, Mouth, Throat
- ❒ Hearing Problems
- ❒ Sinus Problems
- ❒ Throat or Mouth Problems

Cardiovascular - Heart
- ❒ Atrial Fibrillation
- ❒ Abdominal Aortic Aneurysm
- ❒ Angina (chest pain/ discomfort)
- ❒ Arrhythmia - Irregular Heartbeat
- ❒ Blood Clots (DVT) Deep Vein Thrombosis
- ❒ Carotid Artery Disease
- ❒ Congestive Heart Failure
- ❒ Coronary Artery Disease
- ❒ Heart Murmur
- ❒ Heart Valve Disease
- ❒ High Cholesterol
- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Myocardial Infarction-Heart Attack
- ❒ Rheumatic Fever

Respiratory - Breathing
- ❒ Asthma
- ❒ Emphysema
- ❒ Bronchitis
- ❒ Chronic Cough
- ❒ COPD
- ❒ Shortness of Breath
- ❒ Sleep Apnea
  - ❒ CPAP w/Oxygen
  - ❒ CPAP without Oxygen
- ❒ Tuberculosis

Gastrointestinal Disease - Stomach
- ❒ Acid Reflux - Heartburn
- ❒ Colitis - Ulcerative
- ❒ Diverticulitis/ Diverticulosis
- ❒ Gastric Stomach Ulcer
- ❒ Hiatal Hernia
- ❒ Irritable Bowel Syndrome (IBS)

Genitourinary
- ❒ Bladder Incontinence
- ❒ Chronic Dialysis
- ❒ Cystitis - (UTI) Urinary Tract Infection
- ❒ Enlarged Prostate
- ❒ Kidney Stones
- ❒ Prostate Cancer
- ❒ Kidney Insufficiency
- ❒ Kidney Disease/ Failure
- ❒ Uterine Disease

Integumentary Disease (Skin)
- ❒ Eczema
- ❒ Psoriasis

Musculoskeletal (muscles, joints, bones)
- ❒ Arthritis
- ❒ Arthritis (Rheumatoid)
- ❒ Gout
- ❒ Osteoporosis
- ❒ Osteopenia
- ❒ Polymyalgia

Neurological
- ❒ ADHD / ADD
- ❒ Alzheimer's
- ❒ Dementia
- ❒ Anxiety
- ❒ Depression
- ❒ Speech Delay
- ❒ Down Syndrome
- ❒ Cerebral Palsy
- ❒ Multiple Sclerosis
- ❒ Muscular Dystrophy
- ❒ Polio
- ❒ Neuropathy
- ❒ Parkinson's
- ❒ Fibromyalgia
- ❒ Psychiatric Disorder
- ❒ Seizure Disorder
- ❒ Mini Strokes (TIA)
- ❒ Stroke (CVA)

Hematologic/ Lymphatic (Blood)
- ❒ Anemia
- ❒ Bleeding Disorder
- ❒ Blood Transfusions
- ❒ Hepatitis
- ❒ Liver Disease
- ❒ Malignant Hyperthermia

Endocrine
- ❒ Diabetes Mellitus, Type 1 (insulin)
- ❒ Diabetes Mellitus, Type 2 (diet controlled)
- ❒ Diabetes Mellitus, Type 2 (oral meds)
- ❒ Diabetes Mellitus, Type 2 (insulin)
- ❒ Thyroid Disease
  - ❒ Hyperthyroidism
  - ❒ Hypothyroidism
  - ❒ Other

Allergic/ Immunologic
- ❒ AIDS
- ❒ Allergies to:
  - ❒ Medications ______________________
  - ❒ Environmental ______________________
  - ❒ Seasonal ______________________
  - ❒ Food ______________________
  - ❒ Latex ______________________
- ❒ Hay Fever
- ❒ HIV
- ❒ Lupus Erythematous
- ❒ Myasthenia Gravis

Cancer
- ❒ Bladder
- ❒ Breast
- ❒ Colon
- ❒ Hodgkin's
- ❒ Non-Hodgkin's
- ❒ Prostate
- ❒ Skin
  - ❒ Basal Cell
  - ❒ Squamous Cell
  - ❒ Melanoma
- ❒ Leukemia
- ❒ Lung
- ❒ Lymphoma
- ❒ Ovarian
- ❒ Thyroid
- ❒ Uterine
- ❒ Other

History of Infection Disease
- ❒ Chicken Pox
- ❒ Herpes Zoster - Shingles
  - ❒ Shingles Vaccine
- ❒ MRSA
- ❒ Meningitis

Endocrine
- ❒ Chromosome Abnormality
- ❒ Syndrome or identified genetic disease
- ❒ Retinitis pigmentosa
- ❒ Color blindness
- ❒ Other: ____________________

Please list any other health condition you may have that has not been listed:

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